DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G072	A. BUILDING _____ B. WING _____	02/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1318 45TH PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from February 7, 2008, through February 8, 2008. using the full survey process. The census at the time of the survey was 5 (1 male and 4 females) clients. Two clients with various levels of mental retardation were selected for the sample. One client's record was reviewed to focus on healthcare services due to the client being in the hospital at the time of the survey. The findings of the survey were based on observations at the facility and at two day programs, interviews at the home and day programs, and review of clinical and administrative records, including incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's governing body exercised general operating direction over the facility except for the following concerns. The finding includes: 1. The facility's governing body failed to ensure all problems with evacuation drills were investigated and necessary corrective actions were implemented in a timely manner. (See W449) 2. The facility's governing body failed to ensure needed transportation and finances were available to ensure clients were able to participate	W 104	The staff who slept during the shift was terminated on 6-05-07 All staff were inserviced on the evacuation drills. Refer to attachment # 1 (a & B) In the future the facility will ensure that all of problems with the evacuation drills are investigated, and that the necessary corrective actions are implemented on a timely manner. The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation is availble to ensure	2-12-08

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAR -3 P 1:35

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 3/3/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 in active treatment programing. (See W159)	W 104		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to keep confidential all information contained in each client's record, for one of five clients (Client #4) that resided in the facility. The finding includes: Observation of the dining room wall on February 7, 2008 at 8:43 AM revealed a feeding protocol for Client #4 posted on the wall. The feeding protocol documented information including the client's food texture and indicated the client was at risk for choking and aspiration. The Qualified Mental Retardation Professional (QMRP) was interviewed on February 7, 2008, to ascertain information regarding the relevance of the posted protocol and to determine if the protocol was supposed to be posted. The QMRP removed the protocol from the wall and indicated that the protocol should not have been posted. The QMRP further revealed that the protocol was posted inside of a cabinet in the kitchen for staff to review. At the time of the survey, the facility failed to ensure Client #4's information was maintained confidentially.	W 112	All individuals' informations are kept confidentially and unconspiciously. All staff were trained on the confidentially of the individuals' record. In the future, the facility will ensure that all of the individual records are kept confidentally.	2-08-08
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114		

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W 124	Continued From page 3 Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients (Clients #2) included in the sample. The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or her legal guardian for sedations given during medical appointments. Review of Client #2's records on February 7, 2008, at approximately 2:47 PM revealed a written physician order (dated October 14, 2007) that documented the client was to receive Xanax 2 mg one hour before her gynecological appointment on October 17, 2007. Additional review of Client #2's record on February 8, 2008 at 3:43 PM revealed orders dated January 20, 2008, and February 1, 2008, that documented the client was prescribed Xanax 2 mg one hour before her MRI on January 23, 2008, and February 5, 2008, respectively. It should be noted that interview with the Licensed Practical Nurse (LPN) on February 8, 2008 revealed the medications were administered to address	W 124	The facility will ensure that a consent for sedation is obtained, and signed by the family member (for those individuals who have the family involvement) each time the individual has a medical appointment requesting sedation.	2-08-08

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W 124	Continued From page 4 behaviors during medical appointments and further verified that the sedations were administered. Interview with the Qualified Mental Retardation Professional (QMRP) on February 7, 2008 at 10:27 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on February 8, 2008 at 1:40 PM through review of Client #2's psychological assessment dated September 10, 2007. According to the assessment, Client #2 "does not evidence the capacity to make decisions on her behalf in treatment/habilitation, on going medical care, residential placement, and financial matters." Additionally, the QMRP revealed that Client #2 did not have a legal guardian but did have involved family members. At the time of the survey, however, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative for the use of the aforementioned sedations.	W 124	The facility will ensure that a consent for sedation is obtained, and signed by the family member (for those individuals who have the family involvement) each time the individual has a medical appointment requesting sedation.	2-08-08
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure parents/guardians were notified of serious incidents, for one of the five clients (Client #3) that resided in the facility.	W 148		

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W 148	Continued From page 5 The finding includes: Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM revealed one allegation of abuse (dated June 1, 2007) involving Client #3 that was investigated. The facility failed to provide evidence of the corresponding incident report for the aforementioned allegation. Additional review of the incident reports and investigations revealed two more incidents involving Client #3 dated August 17, 2007 and September 12, 2007. The documentation revealed that on August 17, 2007, Client #3 was taken to the hospital for hiccupping and was subsequently diagnosed with having anxiety. The September 12, 2007, incident documented that Client #3 was relocated to a hotel due to the facility's malfunctioning fire alarm system. On February 7, 2008, at 7:58 AM, interview with the facility's House Manager (HM) revealed that Client #3 had an involved family member (sister). At the time of the survey, the facility failed to provide evidence that Client #3's involved family member (sister) was notified of the aforementioned incidents.	W 148	The stated incident dated 6-01-07 was entered in the MCIS by the DDS nurse investigator. A copy of this incident report was faxed to DOH per the surveyor request. Refer to attachment #3 In the future the facility will ensure that the incidemt reports generated by other entities are sent to the Department Of Health, and fully investigated. Client #3 sister was informed on both incidents Refer to attachment #3 (b)	2-11-08
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement and/or develop	W 149		

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W 149	Continued From page 6 policies/procedures that ensure clients' health and safety, for one of the five clients (Client #3) that resided in the facility. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on February 8, 2008, at 10:16 AM was conducted to ascertain information about the facility's incident management system. According to the QMRP, allegations of abuse/neglect, mistreatment and injuries of unknown origin must be immediately reported to the Department of Health, the facility's Chief Operations Officer (COO), the facility's Incident Management Coordinator (IMC) and to the client's family. The initial notification was also followed by written notification within 24 hours to Department of Health. Continued interview with the QMRP revealed that an incident report was completed for all incidents and when documented by staff must be completed prior to the end of their shift. It should be noted that review of the facility's incident management policy (revised November 2007) on February 7, 2008, confirmed the QMRP's statements. Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM revealed one allegation of abuse (dated June 1, 2007) involving Client #3 that was investigated. The facility failed to provide evidence of the corresponding incident report for the aforementioned allegation. Further review of the incident reports revealed an incident involving Client #3 dated January 11, 2008. According to the review of the incident report, the client informed staff that his leg was hurting him. Continued review of the incident report revealed	W 149	The Qmrp was inserviced by the Program Director on the incident management policy. Refer to attachment # 4. In the future the management will ensure that all incidents are reported as spelled on the incident management policy. Refer to W. 148 P.6	2-08-08 2-11-08

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W 149	Continued From page 7 the Department of Health was notified of the incident on January 14, 2008, via fax (3 days after the incident). At the time of the survey, the facility failed to provide evidence that its incident management policy was consistently implemented.	W 149	In reference to the incident dated January 11,08 the Qmrp failed to follow the incident protocol by not reporting the incident on time. He was inserviced by the Program Director on the incident reporting protocol. Refer to attachment # 4 In the future the facility will ensure that all of the incidents are reported according to the incident reporting protocol.	2-08-08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse/neglect and injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for one of the five clients (Client #3) that resided in the facility. The finding includes: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on February 8, 2008, at 10:16 AM was conducted to ascertain information about the facility's incident management system. According to the QMRP, allegations of abuse/neglect, mistreatment and injuries of unknown origin must be immediately reported to the Department of Health, the facility's Chief Operations Officer (COO), the facility's Incident Management Coordinator (IMC) and to the client's family. The initial notification was also	W 153		

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W 153	Continued From page 8 followed by written notification within 24 hours to Department of Health. Continued interview with the QMRP revealed that an incident report was completed for all incidents and when documented by staff must be completed prior to the end of their shift. It should be noted that review of the facility's incident management policy (revised November 2007) on February 7, 2008, confirmed the QMRP's statements. a) Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM revealed an injury of unknown origin involving Client #3 dated January 11, 2008. According to the review of the incident report, the client informed staff that his leg was hurting him. The client was assessed by the nurse and was subsequently taken to the emergency room for further evaluation. Continued review of the incident report failed to provide evidence that the facility's administrator was notified of the incident and revealed the Department of Health was notified of the incident on January 14, 2008, via fax (3 days after the incident). At the time of the survey, the facility failed to provide evidence that the aforementioned incidents were reported as required. b) Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM revealed one allegation of abuse (dated June 1, 2007) involving Client #3 that was investigated. The facility failed to provide evidence of the corresponding incident report for the aforementioned allegation. c) Review of Client #3's medical record revealed a nursing note dated December 3, 2007. The note reflected that the staff reported to the nurse	W 153	Refer to W 149 P.8 Refer to W 149 P.8 Refer to W 148 P.6	2-08-08 2-11-08 2-11-08

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W 153	Continued From page 9 that Client #3 fell on his side with the walker next to him due to a very heavy bag hanging on the walker which pulled him down. Review of the facility's incident reports on February 7, 2008 failed to evidence a corresponding incident report. There was no evidence that the administrator was made aware of this incident as required.	W 153	The Qmrp was inseviced by the Program Director on the incident reporting protocol. In the future the Qmrp will ensure tha administrator is notified each time an incident occurs.	2-08-08
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated, for one of the five (Clients #3) that resided in the facility. The finding includes: Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM revealed an injury of unknown origin involving Client #3 dated January 11, 2008. According to the review of the incident report, the client informed staff that his leg was hurting him. The client was assessed by the nurse and was subsequently taken to the emergency room for further evaluation. Review of the corresponding investigation (dated January 15, 2008) revealed that upon arriving home from dialysis, Client #3 refused to exit the van. When Client #3 exited the van, staff attempted to assist him into the facility, but the client was noted to be verbally and physically abusive. The investigation further documented	W 154	Refer to W 148 P. 6	2-11-08

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W 154	Continued From page 10 that the client fell. Continued review of the investigation revealed additional staff from the facility were solicited to assist Client #3 up from the ground due to the client's refusal to get up. "Staff reported they were able to encourage Client #3 to sit in a wheelchair to be taken into the home." Other than the staff person that reported the incident, the investigation failed to document the name of any staff person that was interviewed (including statement if necessary) or potentially witnessed the incident. It should be further noted that there was no evidence that Client #3 was interviewed. Review of the incident management policy on February 7, 2008, revealed a section entitled "Incident Investigation." According to that section, the policy documented that the following types of evidence should be collected if relevant: Testimonial evidence, by interviewing, one person at a time - Any victims of the incident - Any witnesses with relevant information regarding the incident, including customer, staff, or other persons, and the determined target of the investigation. Documentary evidence, where relevant, such as: - Progress notes maintained for the customer - Staffing schedules or assignment sheets - Behavior programs and supporting documentation Interview with the Qualified Mental Retardation Professional (QMRP) on February 7, 2008 at 10:27 AM revealed that Client #3 was prescribed	W 154	Currently the Qmrp is collecting the witness statements from all of the staff that were present during the incidents for the purpose of completing an investigation. The Qmrp will follow the incident protocol. 2-08-08 In the future the Qmrp will ensure that all of the witness statements are collected as spelled in the incident ininvestigation.	investigation

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W 154	Continued From page 11 psychotropic medication and used a Behavior Support Plan to address maladaptive behaviors. At the time of the survey, the facility failed to provide evidence that the aforementioned incident had been thoroughly investigated.	W 154	Currently the Qmrp is collecting the witness statement from all of the staff that was present during the incidents fot the purpose of completing an investigation. The Qmrp will follow the incident protocol. 2-08-08 In the future the Qmrp will ensure that all of the witness statements are collected as spelled in the incident ininvestigation.	investigation
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for two of the five clients (Clients #2 and #3) that resided in the facility. The finding includes: Review of the facility's incident reports and investigations on February 7, 2008 beginning at 9:45 AM , revealed the facility failed to provide evidence that the administrator or designee reviewed the results of investigations within five working days of the incident as detailed below: 1. On January 11, 2008, staff reported that Client #3 informed staff that his leg was hurting. The client was assessed by the nurse and was subsequently taken to the emergency room for further evaluation. Review of the corresponding investigation dated January 15, 2008 revealed the investigation was completed by the Qualified Mental Retardation Professional (QMRP) and	W 156	Refer to W 153 P. 10	2-08-08

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W 156	Continued From page 12 was not reviewed by the administrator or a designee. 2. On June 1, 2007, an allegation of abuse was made involving Client #3. Review of the corresponding incident investigation revealed that the investigation was completed by the incident management coordinator on August 2, 2007. 3. On August 27, 2007 Client #2's fell while trying to run away from staff. Review of the corresponding investigation revealed the investigation was completed by the QMRP and was not reviewed by the administrator or a designee. 4. On May 3, 2007, Client #2 fell in the facility. The corresponding investigation was completed by the QMRP and was not reviewed by the administrator or a designee. At the time of the survey, the facility failed to ensure that the administrator or designee reviewed the results of all investigations within five working days of the incident.	W 156	Refer to W 153 P. 10 Refer to W 153 P. 10 Refer to W 153 P. 10	2-08-08 2-08-08 2-08-08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP).	W 159		

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W 159	Continued From page 13 The findings include: 1. The QMRP failed to ensure transportation and/or funds were available for clients go on medical appointments and/or to participate with their formal program objectives. a. Review of Client #2's records on February 8, 2008 at 12:38 PM revealed the client's Individual Support Plan (ISP) dated October 21, 2007. Interview with the QMRP and review of Client #2's corresponding Individual Program Plan (IPP) on February 8, 2008 at 1:22 PM revealed the client had program objectives including the following: Client #2 will go to the hair salon to get her hair done twice a month at 100% of trials for 6 consecutive months by 9/08. Review of the corresponding data collection record revealed that on January 12, 2008 her appointment was rescheduled. On January 19, 2008, and January 20, 2008, staff documented that there was no transportation available. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. Client #2 will go to the nail salon to her nails done twice a month at 100% of trials for 6 consecutive months by 9/07. Review of the corresponding data collection record revealed that on January 12, 2008 her appointment was rescheduled. On January 19, 2008, and January 20, 2008, staff documented that there was no transportation available. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form.	W 159	The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation is availble to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled. The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation is availble to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled.	2-12-08 2-12-08

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W 159	Continued From page 14 Client #2 will attend church service with staff with verbal prompts on 3 out of 4 trials for 6 consecutive months. Review of the corresponding data collection record revealed that on January 6, 2008, there were keys available for the van and on January 20, 2008, there was no transportation available. Continued review of the data collection for the month of February 2008 revealed that on February 3, 2008 staff documented that the program was not implemented due to being "short staff." It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. Client #2 will make a small purchase of her choice with verbal prompts from staff on 3 out of 4 trials per month for 6 consecutive months by 9/07. Review of the corresponding data collection record revealed that on January 19, 2008, there was no transportation available to implement the program and on February 2, 2008, there was no money available to implement the program. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. b. Review of Client #2's medical record on February 8, 2008 at 9:17 AM revealed the client was seen by a neurologist on June 21, 2007. According to the consultation form, the client was to return for follow up services in one month (July 12, 2007). Further review of the client's record revealed the client's next neurological consultation was on September 26, 2007. Interview was conducted with the residential Licensed Practical Nurse (LPN)on February 8, 2008, at 4:29 PM to ascertain information as to	W 159	The new van was purchased 2-12-08 Refer to attachment #2 In the future the facility governing body will ensure that transportation is availble to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled; additional the facility is cuurnetly full staffed. Refer to attachment #5 The new van was purchased 2-12-08 Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funds are availble to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled. The new van was purchased 2-12-08 Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funfs are availble to ensure that individuals participate in the active treatment programing, and attend the medical appointments as scheduled.	

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W 159	Continued From page 15 why the client missed her scheduled July 12, 2007, follow up with the neurologist. According to the LPN, the client missed the appointment due to transportation issues. At the time of the survey, the facility's QMRP failed to ensure necessary funds and/or transportation was available to make certain required medical appointments and active treatment programs were completed. 2. The QMRP failed to ensure that as soon as the Interdisciplinary Team (IDT) formulated each client' s Individual Program Plan (IPP), clients received continuous active treatment, consisting of needed interventions and services. (See W249) 3. The QMRP failed ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less intrusive techniques had been attempted. (See W278) 4. The QMRP failed to ensure that drugs used to control inappropriate behavior were used only as an integral part of the client's individual program plan that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. (See W312) 5. The QMRP failed to ensure each the client's had recommended self medication administration programs and made certain they were monitored. (See W227)	W 159	1 The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funds are available to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled. Refer to W. 249 P.20 Refer to W 278 P. 22 Refer to W 312 P. 23 Refer to W 227 P. 17	2-12-08 2-08-08 3-01-08 3-01-08 2-08-07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189		

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W 189	Continued From page 16 initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to provide each employee initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. The findingincludes : [Cross refer to citation W474] The facility failed to ensure effective training regarding the preparation of client meals.	W 189		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the individual program plan (IPP) included objectives to meet the client's needs, for two of the five clients (Clients #1and #2) that resided in the facility. The findings include: 1. The facility failed to ensure Client #2's identified need regarding an objective in the domain of self medication administration was documented in her IPP.	W 227	Individual # 2 objective in the domain of self medication administration has been documented in her IPP. Refer to attachment #6 (a) In the future the facility will ensure that all of the individuals objectives for self medication are documented in their IPPS.	2-08-08

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W 227	Continued From page 17 On February 8, 2008 at 7:07 AM Client #2 received her routine medications. The nurse punched pills into a cup and poured liquid medication into a separate cup. Client #2 retrieved the cups from the table and independently consumed the medication. Review of Client #2's record on on February 8, 2008 at 11:24 AM revealed the client's self-medication assessment dated January 16, 2008. According to the assessment, Client #2 was approved to participate with a self medication administration program. The assessment further documented the following recommendation for programming: "[Client #2] will take a cup of medicine, put it in her mouth and a cup of water from the nurse and put it in her mouth." Further review of Client #2's record on February 8, 2008 at 12:38 PM revealed the client's Individual Support Plan (ISP) dated October 21, 2007. The ISP had a corresponding IPP that documented program goals and objectives except for an objective in the domain of self medication administration. Review of the Qualified Mental Retardation Professional's (QMRPs) monthly notes additionally failed to document any information regarding a program objective for Client #2 relating to self medication administration. Interview was conducted with the QMRP on February 8, 2008 to ascertain if a formal program objective in self medication administration existed for Client #2. At the time of the survey, the facility failed to provide evidence that an IPP existed for	W 227	Individual # 2 objective in the domain of self medication administration has been documented in her IPP. Refer to attachment #6 (a) In the future the facility will ensure that all of the individuals objectives for self medication are documented in their IPPS.	2-08-08

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W 227	Continued From page 18 Client #2 in the domain of self medication administration. 2. The facility failed to ensure Client #1's identified need regarding an objective in the domain of self medication administration was documented in her IPP. On February 8, 2008 at 8:10 AM Client #1 received her routine medications. The nurse punched pills into a cup and poured a liquid dietary supplement into a separate cup. Client #2 retrieved the cups from the table and independently consumed the contents. Review of the client's self medication assessment dated January 15, 2008, indicated that the client was "a candidate for self medication program with supervision." Interview was conducted with the QMRP on February 8, 2008 to ascertain if a formal program objective in self medication administration existed for Client #1. At the time of the survey, the facility failed to provide evidence that an IPP existed for Client #1 in the domain of self medication administration.	W 227	Individual # 1 objective in the domain of self medication administration has been documented in her IPP. Refer to attachment #6 (b) In the future the facility will ensure that all of the individuals objectives for self medication are documented in their IPPS.	2-08-08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to provide continuous active treatment, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Review of Client #1's Individual Program Plan (IPP) dated December 27, 2007 on February 8, 2008, revealed a program objective in the daily living domain that indicated that the client "will remove nail polish from her fingernails with gestural prompts from staff on 8/10 consecutive trails . . ." Review of the available program data for January 2008 through February 2008, revealed that the program could not be run due to the client not having any nail polish on. 2. Review of Client #1's IPP dated December 27, 2007 on February 8, 2008, revealed a program objective in the money management domain that indicated that the client "will make a purchase of at least two items that she she likes with verbal prompts from staff on three -4 trials per month . . . " Review of the program data revealed that on January 19, 2008 the program could not be implemented due to "no van."	W 249	The fingernail polish has been purchased, and the staff are implementing the the goal; in addtion individual #1 will go to the beauty parlor to have her nails done as described on the objective. The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funds are available to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled.	2-08-08 2-12-08
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by:	W 252		

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W 252	Continued From page 20 Based on interview and record review, the facility failed to collect data in accordance with clients' training programs, for one of the two clients in the sample. (Client #1) The finding includes: On February 7, 2007 at 4:09 PM Client #1 was at the dining room table with her peers. The staff offered the client an arts and craft project. The client participated by using coloring and applying glitter to the paper. Review of the program objective revealed that the client will participate in an arts and crafts activity. Review of the data sheets on February 8, 2008 at 2:42 PM revealed that the staff were to document the type of arts and crafts the client participated in, however there was not enough room on the form for the staff to document the aforementioned information. This information was brought to the attention of the QMRP by the surveyor.	W 252	The data sheet was revised to provide enough room in the form for the staff to document the type of arts and crafts individual # 1 has participated in. Refer to attachment #7 In the future, the Qmrp will ensure that the data sheet accommodates the documentation of the objective.	2-08-08
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less	W 278		

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W 278	Continued From page 21 intrusive techniques had been attempted and were ineffective, for one of the two clients (Client #2) included in the sample. The finding includes: Review of Client #2's records on February 7, 2008, at approximately 2:47 PM revealed a written physician order (dated October 14, 2007) that documented the client was to receive Xanax 2 mg one hour before her gynecological appointment on October 17, 2007. Additional review of Client #2's record on February 8, 2008 at 3:43 PM revealed orders dated January 20, 2008, and February 1, 2008, that documented the client was prescribed Xanax 2 mg one hour before her MRI on January 23, 2008, and February 5, 2008. It should be noted that interview with the Licensed Practical Nurse (LPN) on February 8, 2008 revealed the medications were administered to address behaviors during medical appointments, and further verified that the sedations were administered. Interview with the House Manager (HM) on February 7, 2008 at 7:58 AM and review of records on February 8, 2008 at 2:41 PM revealed that Client #2 had a Behavior Support Plan (BSP) that addressed non-compliance, physical aggression, eloping and behaviors associated with dysphoria. There was no eidence that client behaviors during medical examinations/treatments were addressed prior to the use of sedatives.	W 278	The Psychologist will develop a BSP for individual #2 addressing the behaviors during the medical examinations/ treatments. In the future the management will ensure that the less intrusive techniques have been attempted and were ineffective prior to the use of the intrusive ones.	3-01-08
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed	W 312		

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W 312	Continued From page 22 specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure drugs used to control inappropriate behavior were used only as an integral part of the client's individual program plan that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed, for one of the two clients (Client #2) included in the sample. The finding includes: Review of Client #2's records on February 7, 2008, at approximately 2:47 PM revealed a written physician order (dated October 14, 2007) that documented the client was to receive Xanax 2 mg one hour before her gynecological appointment on October 17, 2007. Additional review of Client #2's record on February 8, 2008 at 3:43 PM revealed orders dated January 20, 2008, and February 1, 2008, that documented the client was prescribed Xanax 2 mg one hour before her MRI on January 23, 2008, and February 5, 2008. It should be noted that interview with the Licensed Practical Nurse (LPN) on February 8, 2008 revealed the medications were administered to address behaviors during medical appointments, and further verified that the sedations were administered. Interview with the House Manager (HM) on February 7, 2008 at 7:58 AM and review of records on February 8, 2008 at 2:41 PM revealed	W 312	The Psychologist will develop a BSP for individual #2 addressing the behaviors during the medical examinations/ treatments. In the future the management will ensure that the less intrusive techniques have been attempted and were ineffective prior to the use of the intrusive ones.	3-01-08

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W 312	Continued From page 23 that Client #2 had a Behavior Support Plan (BSP) that addressed non-compliance, physical aggression, eloping and behaviors associated with dysphoria. There was no eidence that client behaviors during medical examinations/treatments were addressed prior to the use of sedatives.	W 312		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services were obtained, for one of the two clients (Client #2) included in the sample. The finding includes: Review of Client #2's records on February 8, 2008 at 10:34 AM revealed the client was seen for dental services on February 21, 2007. According to the dental consultant, the patient required scaling and preauthorization for the scaling was going to be submitted by the dentist. Once the preauthorization was obtained the client would be scheduled for the dental service (scaling). Further review of the record revealed the nurse made calls to the dentist as late as May 2007 to find out if the preauthorization had been obtained. Continued review of Client #2's dental record	W 356	Individual #2 dental appointment is scheduled In the future, the facility nurse will ensure that the dental treatment is completed as scheduled. In the event of the pre-authorization, the nurse will follow-up by calling the dentist's office on a regular basis, and document the attempts.	4-07-08

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W 356	Continued From page 24 revealed the client was seen by the dentist on September 10, 2007 (extraction of tooth #20 performed) and October 10, 2007 (follow up after the extraction). There was no evidence that the recommended scaling was addressed. Interview was conducted with the residential Licensed Practical Nurse (LPN) on February 8, 2008 to ascertain if Client #2 had received the recommended scaling. The LPN verified that calls were made as late as May 2007 to find out if the preauthorization for the service was granted, however, at the time of the survey, the facility failed to provide evidence that Client #2 received the recommended dental service (scaling).	W 356	Individual #2 dental appointment is scheduled In the future, the facility nurse will ensure that the dental treatment is completed as scheduled. In the event of the pre-authorization, the nurse will follow-up by calling the dentist's office on a regular basis, and document the attempts.	4-07-08
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medications were appropriately stored and secured for one of the five clients in the facility. (Client #3) The finding includes: A small brown refrigerator was observed in the dining room area. The surveyor opened the refrigerator and found a black locked box in the shelf and a bag from the pharmacy that contained insulin for Client #3. Additionally there was an opened box containing Insuline and an opened vial of Tuberculin vaccine. The nurse was asked to open the locked box. The box contained six boxes that contained insulin for Client #3. The	W 381	The facility has installed a lock and padlock that keep the refrigerator locked at all times. In the future the facility will ensure that the refrigerator containing the medications is locked at all times.	2-08-08

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W 381	Continued From page 25 nurse acknowledged that there was an excessive amount of insulin and that the refrigerator was not locked.	W 381		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of five clients that reside in the facility. (Client #3) The finding includes: During the entrance conference held with the facility's licensed practical nurse on February 7, 2008 at 9:00 AM revealed that Client #3 had been admitted to the hospital on January 28, 2008. During the review of Client #3's medical record to ascertain information regarding his health status prior to his hospitalization revealed that the client was a diabetic controlled by insulin. The medical record reflected that the nursing staff performed fingersticks on the client for blood sugar monitoring. Observation of the medication administration area on February 8, 2008, revealed that the Clinical Laboratory Improvement Act (CLIA) certificate on the wall expired on February 15, 2007. The finding was brought to the attention of the LPN's present at that time. additionally this information will be referred to the laboratory surveyor for review.	W 393	The Lab improvement Act expired on 2-15-08. The recertification for the clinical Lab improvement Act has been submitted. In the future, the facility will ensure that the clinical Labs imrovement Act is current in order to continue to monitor blood glucose in the home.	3-03-08
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair,	W 436		

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W 436	Continued From page 26 and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure necessary adaptive equipment was furnished and/or maintained and client's were taught to make informed choices about their use, for one of the two clients (Client #2) included in the sample. The finding includes: Observation on February 7, 2008 during the morning medication administration at 7:53 AM revealed the nurse using sign language in order to communicate with Client #2. Review of Client #2's record on February 7, 2008 at 4:01 PM revealed the client was seen by an audiologist on March 27, 2007. According to the corresponding consultation form, the audiologist documented that the client should continue using her hearing aid. It should be noted that throughout the survey, Client #2 was not observed to wear her hearing aid. Interview was conducted with the residential Licensed Practical Nurse (LPN) on February 8, 2008 at 3:35 PM to ascertain information about the client's hearing aid and its usage. According to the LPN, the client had two hearing aids, one was maintained at the day program and one was maintained in the residential nurse's station . The	W 436	The staff and nurses will provide the hearing aid to individual #2 on a daily basis, and ensure that she keeps the device on her ear. Training was provided to individual #2 that emphasized the importance of the use of the device. In the future the facility will ensure that individual # 2 wears her earing aid on a daily basis.	2-08-08

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W 436	Continued From page 27 nurse further revealed that the client would put the hearing aid in the trash or would not wear it when given to her. At the time of the survey, however, the facility failed to provide evidence that Client #2 was being provided training using and maintaining her recommended hearing aid.	W 436		
W 443	483.470(i)(1)(ii) EVACUATION DRILLS The facility must hold evacuation drills to ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features. This STANDARD is not met as evidenced by: Based on staff interview and review of the facility's training records, the facility failed to ensure that all personnel was trained and familiar with the use of the facility's fire protection features. The finding includes: During the review of the fire drill records on February 7, 2008, at 9:10 AM it was discovered that a drill conducted on July 11, 2007, documented the following problem during the drill: "Fire alarm not set up properly. It took 20 min until the fire fight[sic] came and stopped the alarm." Interview with the QMRP on the same day revealed that he felt that the problem with drill was user error, however when asked if subsequent training on the alarm system had been conducted at that time, he indicated that there had been no training.	W 443	All staff was inserviced on the proper use of the fire alarm panel, and procedures for trouble shouting. Refer to attachment #9 In the future the facility will ensure that staff are properly trained in the fire alarm panel, and trouble shouting.	2-18-08
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents.	W 448		

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W 448	Continued From page 28 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to investigate all problems identified during evacuation drills. The findings include: 1. During the review of the fire drill records on February 7, 2008, at 9:10 AM, it was discovered that on June 1, 2007 a "problem" was encountered during the drill. It was documented that staff was "sleep before the drill was done. This stop clients from getting out on time. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day, revealed that although he had reviewed the drill report, there had not been an investigation into the incident. 2. On July 11, 2007, a drill was held. The problem encountered during the drill was documented as follows: "Fire alarm not set up properly. It took 20 min until the fire fight[sic] came and stopped the alarm." Interview with the QMRP on the same day revealed that he felt that the problem with drill was user error, however when asked if subsequent training on the alarm system had been conducted at that time, he indicated that there had been no training. 3. Review of the drills conducted from March 2007 through January 2008, revealed that Clients #2 and #3 frequently refuse to leave the facility during drills. According to the fire drill records, dated December 15, 2007, the QMRP spoke with the client in an effort to get him to cooperate during the drills. the drill record indicated that the client stated that he would cooperate during the	W 448	The staff who slept during the drill was terminated on 6-05-07 Refer to attachment #1a In the future the Qmrp will ensure that all incidents that occured during the drills are investigated. All staff was inserviced on the proper use of the fire alarm panel, and procedures for trouble shouting. Refer to attachment #9 In the future the facility will ensure that staff are properly trained in the fire alarm panel, and trouble shouting. All staff were trained on the way to evacuate individuals who refuse, or are unconscious and unable to leave the facility. In the future the facility will ensure that the staff are properly trained on the problems that occur during the drills.	2-18-08 2-18-08

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W 448	Continued From page 29 next drill, however, during the drill held on December 17, 2007, the client refused to leave the facility. The QMRP again spoke with the client who again indicated that he would cooperate during the next drill, however on the drill conducted on January 6, 2008, Client #3 refused to leave the facility. Interview with the QMRP on the same day revealed that a "safety talk" is conducted with the client when he refuses to leave the facility. The QMRP acknowledged that the talks rarely lead to the client's cooperation during the drills. When asked if the client is allowed to remain in the facility during the drills the QMRP indicated that he was. When asked if the staff were trained in removing clients from the facility in case of emergency i.e. unconscious, non-ambulatory, etc. the QMRP indicated that they had not received training prior to the survey.	W 448	All staff were trained on the way to evacuate individuals who refuse, or are unconscious and unable to leave the facility. In the future the facility will ensure that the staff are properly trained on the problems that occur during the drills. Refer to attachment 1 b.	2-07-08
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to investigate all problems which occurred with the evacuation drills and take corrective action. The finding includes: [Cross refer to citation W448] The facility failed to investigate problems identified during fire drills such as; sleeping staff, problems with either the fire panel or staff knowledge on the operation of the panel and client cooperation during drills	W 449	Refer to W 443 P.28, W 448 P. 28 W 448 P.29 (1,2,3)	2-07-08

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W 449	Continued From page 30 which could pose a safety risk for the client and staff.	W 449		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture for one of the two clients in the sample. (Client #1) The findings include: On February 7, 2008 at 4:05 PM, Client #1 was observed eating her snack. The snack consisted of Jello, a piece of cake and some juice. The client consumed all of the cake, 75% of the jello and all of the juice. On February 8, 2008, at 7:51 AM Client #1 received her breakfast. The client's food was noted to be pureed. Review of Client #1's nutritional assessment dated December 10, 2007, revealed that client is prescribed a pureed diet. At the time of the survey, Client #1 was not provided with a pureed diet.	W 474	All staff were in-serviced on individual's #1 diet. Refer to attachment #10 In the future, the facility will ensure that the individuals receive their diets as prescribed.	2-07-08
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, direct care staff interviews, the facility failed to provided opportunities and	W 488		

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W 488	Continued From page 31 encouragement for clients to feed themselves to the extent of their abilities for one of two clients in the sample. (Client #1) The finding includes: On February 7, 2008 at 4:05 PM, Client #1 was observed eating her snack. The snack consisted of Jello, a piece of cake and some juice. The client consumed all of the cake, 75% of the jello and all of the juice. Client #1 ate without assistance from staff using regular utensils. On February 8, 2008, at 7:51 AM Client #1 received her breakfast. The client's food was noted to be pureed. The staff was observed feeding the client. Interview with the staff revealed that they sometimes feed the client to get her to eat, however Client #1 was not afforded an opportunity to feed herself prior to the staff doing so. Staff stated Client #1 could feed herself but "won't" and would "sit here and won't eat." Review of Client #1's nutritional assessment dated December 10, 2007, revealed that client was a self-feeder. At the time of the survey, Client #1 was not afforded an opportunity to utilize her self-feeding skills.	W 488	All staff were inserviced on the individual's #1 meal protocol according to the nutritional assessment Refer to attachment #11 In the future the facility will ensure that the the staff follow the meal protocol.	2-07-08

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I 000	INITIAL COMMENTS An annual relicensure survey was conducted from February 7, 2008 through February 8, 2008. A random sample of two residents was selected from a residential population of five residents (one male and four females) with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including incident reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that modified diets were served as prescribed, for one of the two residents (Resident #1) included in the sample. The finding includes: On February 7, 2008 at 4:05 PM, Client #1 was observed eating her snack. The snack consisted of Jello, a piece of cake and some juice. The client consumed all of the cake, 75% of the jello and all of the juice. On February 8, 2008, at 7:51 AM Client #1 received her breakfast. The client's food was noted to be pureed. Review of Client #1's nutritional assessment dated December 10, 2007, revealed that client is prescribed a pureed	I 042	All staff were in-serviced on individual's #1 diet. Refer to attachment #10 In the future, the facility will ensure that the individuals receive their diets as prescribed.	2-07-08

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I 042	Continued From page 1 diet. At the time of the survey, Client #1 was not provided with a pureed diet.	I 042		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation and interview with the Facility Coordinator during the environmental walkthrough on February 8, 2008 revealed the following: c. The threshold between the kitchen and dining room floors was uneven posing a potential trip/fall hazard.	I 090	The threshold between the kitchen and dining room floor was repaired. In the future, the facility will ensure that the floor is in good condition in order to prevent a potential trip/fall.	2-08-08
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by:	I 180		

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I 180	Continued From page 2 Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans, for two of the two residents (Resident #1 and #2) included in the sample. The finding includes: 1. The QMRP failed to ensure problems identified during fire drills are investigated. [See W448 and 443] 2. The QMRP failed to to ensure effective training on the preparation of resident meals. [See W474] 3. The QMRP failed to ensure medication was stored under secure conditions. [See W381] 4. The QMRP failed to ensure transportation and/or funds were available for residents go on medical appointments and/or to particlpate with their formal program objectives. A. Review of Resident #2's records on February 8, 2008 at 12:38 PM revealed the resident's Individual Support Plan (ISP) dated October 21, 2007. Interview with the QMRP and review of Resident #2's corresponding Individual Program Plan (IPP) on February 8, 2008 at 1:22 PM revealed the resident had program objectives including the following: Resident #2 will go to the hair salon to get her hair done twice a month at 100% of trials for 6 consecutive months by 9/08. Review of the	I 180	All staff were in-serviced on individual's #1 diet. Refer to attachment #10 In the future, the facility will ensure that the individuals receive their diets as prescribed. The facility has installed a lock and padlock that keeps the refrigerator locked at all times. In the future the facility will ensure that the refrigerator containing the medications is locked at all times. The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funds are available to ensure that individuals participate in the active treatment programing, and attend the medical appointments as scheduled.	2-07-08 2-08-08 2-12-08

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I 180	Continued From page 3 corresponding data collection record revealed that on January 12, 2008 her appointment was rescheduled. On January 19, 2008, and January 20, 2008, staff documented that there was no transportation available. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. Resident #2 will go to the nail salon to her nails done twice a month at 100% of trials for 6 consecutive months by 9/07. Review of the corresponding data collection record revealed that on January 12, 2008 her appointment was rescheduled. On January 19, 2008, and January 20, 2008, staff documented that there was no transportation available. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. Resident #2 will attend church service with staff with verbal prompts on 3 out of 4 trials for 6 consecutive months. Review of the corresponding data collection record revealed that on January 6, 2008, there were keys available for the van and on January 20, 2008, there was no transportation available. Continued review of the data collection for the month of February 2008 revealed that on February 3, 2008 staff documented that the program was not implemented due to being "short staff." It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. Resident #2 will make a small purchase of her choice with verbal prompts from staff on 3 out of 4 trials per month for 6 consecutive months by 9/07. Review of the corresponding data	I 180	The new van was purchased Refer to attachment #2 In the future governing body will ensure that transportation, and funds are available to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled. The new van was purchased Refer to attachment #2 In the future the facility governing body will ensure that transportation, and funds are available to ensure that the individuals participate in the active treatment programing, and attend the medical appointments as scheduled.	2-12-08 2-12-08

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I 180	Continued From page 4 collection record revealed that on January 19, 2008, there was no transportation available to implement the program and on February 2, 2008, there was no money available to implement the program. It should be noted that the QMRP's signature documenting that the data collection was reviewed was present on the data collection form. B. Review of Resident #2's medical record on February 8, 2008 at 9:17 AM revealed the resident was seen by a neurologist on June 21, 2007. According to the consultation form, the resident was to return for follow up services in one month (July 12, 2007). Further review of the resident's record revealed the resident's next neurological consultation was on September 26, 2007. Interview was conducted with the residential Licensed Practical Nurse (LPN)on February 8, 2008, at 4:29 PM to ascertain information as to why the resident missed her scheduled July 12, 2007, follow up with the neurologist. According to the LPN, the resident missed the appointment due to transportation issues. At the time of the survey, the facility's QMRP failed to ensure necessary funds and/or transportation was available to make certain required medical appointments and active treatment programs were completed. 5. The QMRP failed to ensure that as soon as the Interdisciplinary Team (IDT) formulated each resident' s Individual Program Plan (IPP), residents received continuous active treatment, consisting of needed interventions and services. (See W249) 6. The QMRP failed ensure that prior to the use	I 180	The new van was purchased Refer to attachment #2 In the future the governing body will ensure that transportation, and funds are available to ensure that individuals participate in the active treatment programing, and attend the medical appointments as scheduled. The new van was purchased Refer to attachment #2 In the future the governing body will ensure that transportation, and funds are available to ensure that individuals participate in the active treatment programing, and attend the medical appointments as scheduled. The fingernail polish has been purchased, and the staff are implementing the the goal; in addtion individual #1 will go to the beauty parlor to have her nails done as described on the objective.	2-12-08 2-12-08 2-08-08

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I 180	Continued From page 5 of more restrictive techniques, the resident's record documented that programs incorporating less intrusive techniques had been attempted. (See W278) 7. The QMRP failed to ensure that drugs used to control inappropriate behavior were used only as an integral part of the resident's individual program plan that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. (See W312) 8. The QMRP failed to ensure each the resident's had recommended self medication administration programs and made certain they were monitored. (See W227)	I 180	The Psychologist will develop a BSP for individual #2 addressing the behaviors during to medical examinations/ treatments. In the future the management will ensure that the less intrusive techniques have been attempted and were ineffective prior to the use of the intrusive ones. Refer to W 312 P.22 Refer to W 227 (1) P.17	3-01-08 3-01-08 2-08-08
I 203	3609.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the Qualified Mental Retardation Professional on February 8, 2008 and review of the GHMRP's personnel files on February 7, 2008 at 1:27 PM revealed the GHMRP failed to provide evidence that three direct care staff and four nurses had the contents of their job descriptions discussed with them at the beginning	I 203	All of the staff job descriptions will be on file In the future, the facility will ensure that the staff record are on file, and availble upon request.	3-15-08

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I 203	Continued From page 6 of their employment and/or annually thereafter.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional on February 8, 2008 and review of the GHMRP's personnel files on February 7, 2008 at 1:27 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for two consultants, three nurses, and nine staff.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 229	All of the staff health certifiactes will be on file In the future tha facility will ensure that all of the staff health certifcates are on file, and availlable upon request.	3-15-08

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I 229	Continued From page 7 (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained on each resident's prescribed diet, for one of the two residents (Resident #1) included in the sample. The finding includes:	I 229	All staff were inserviced on individual #1 diet Refer to attachment #10 In the future, the facility will ensure that the individuals receive their diets as prescribed.	2-07-08
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to maintain each residents' records, for two of the two residents (Resident #1 and #2) included in the sample. The finding includes: 1. Review of Resident #2's medical record on February 8, 2008 at 10:54 AM revealed the client's nursing assessment dated September 5, 2007. The assessment was not signed by the person that assessed the client. Interview with the residential Licensed Practical Nurse (LPN) on February 8, 2008 at 3:08 PM revealed that a Registered Nurse (RN) was contracted to complete the assessment. At the time of the	I 260	The new DON is oversighting all of the medical and nursing record to ensure proper entries. In the future, the nursing department will ensure that all of the record are signed by the person who made the entry.	2-07-08

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I 260	Continued From page 8 survey, the facility failed to ensure Resident #2's assessment was signed as required. 2. Review of Resident #3's medical record on February 7, 2008, revealed a written order for a physical therapy consultation. Although the physician's assistant (PA) who made the entry signed the order, the date the order was made could not be determined. Interview with the facility's LPN revealed that the entry was made on January 30, 2008, at a time when the Primary Care Physician was present, however, the PA entering the order did not date the entry as required. (See also Federal Deficiency Report Citation W114)	I 260	The new DON is oversighting all of the medical and nursing record to ensure proper entries. In the future, the nursing department will ensure that all of the record are signed by the person who made the entry.	2-07-08
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute Is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of all staffs personnel records. The finding Includes: Interview with the Qualified Mental Retardation Professional (QMRP) on February 8, 2008 and review of the GHMRP's personnel files on	I 271		

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I 271	Continued From page 9 February 7, 2008 at 1:27 PM revealed the facility failed to provide evidence of personnel records for two staff, the QMRP, and one nurse.	I 271	See Kwaku	
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of contracts with each of their consultants. The finding includes: Interview with the Qualified Mental Retardation Professional on February 8, 2008 and review of the GHMRP's personnel files on February 7, 2008 at 1:27 PM revealed the GHMRP failed to have contracts on file for its primary care physician.	I 274	The Primary Care Physician contract is currently on file. In the future, the facility will ensure that all the clinicians' contracks are on file, and availble upon request.	2-29-08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within	I 379		

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I 379	Continued From page 10 twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the five residents (Resident #3) that resided in the facility. The finding includes: Review of the GHMRP's incident reports and investigations on February 7, 2008 beginning at 9:45 AM , revealed the facility failed to provide evidence that the Department of Health was notified of the following incidents (within 24 hours) as required: - On August 17, 2007, review of an incident investigation dated August 21, 2007, revealed that Resident #3 was taken to the emergency room after hiccupping. It should be noted that the GHMRP failed to provide evidence of the corresponding incident report that documented notifications for the aforementioned incident. - On September 12, 2007, review of an incident investigation dated September 12, 2007, revealed Resident #3 was taken to an area hotel after the GHMRP discovered the fire alarm system was malfunctioning. It should be noted that the GHMRP failed to provide evidence of the corresponding incident report that documented notifications for the aforementioned incident.	I 379	The incident report was completed on August 20, 07 Refer to attachment #3 The incident report was completed on 9-12-07 Refer to attachment #3	

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I 379	Continued From page 11 - Review of an Incident investigation dated August 2, 2007, revealed that on June 1, 2007, Client #3 made an allegation of abuse. It should be noted that the GHMRP failed to provide evidence of the corresponding incident report that documented notifications for the aforementioned incident. - Review of the nursing notes dated December 3, 2007 revealed that Client #3 fell on his side. The GHMRP failed to have evedence that the incident was documented and reported. At the time of the survey, the GHMRP failed to provide evidence that the Department of Health was made of the aforementioned incidents in a timely manner as required. (See also Federal Deficiency Report Citation W153)	I 379	The stated incident dated 6-01-07 was entered in the MCIS by the DDS nurse investigator. A copy of this incident report was faxed to DOH pe rthe surveyor request. Refer to attachment #3 (a) In the future the facility will ensure that the incident report generated by other entities is sent to the Department Of Health, and fully investigated. The incident report was completed on was documented 12-04-07 refer to attachment #3	2-11-08
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure professional services were received in a timely manner, for one of the two residents (Residents #2) included in the sample. The findings include:	I 401		

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I 401	Continued From page 12 1. Review of Resident #2's records on February 8, 2008 at 10:34 AM revealed the resident was seen for dental services on February 21, 2007. According to the dental consultant, the patient required scaling and preauthorization for the scaling was going to be submitted by the dentist. Once the preauthorization was obtained the resident would be scheduled for the dental service (scaling). Further review of the record revealed the nurse made calls to the dentist as late as May 2007 to find out if the preauthorization had been obtained. Continued review of Resident #2's dental record revealed the Resident was seen by the dentist on September 10, 2007 (extraction of tooth #20 performed) and October 10, 2007 (follow up after the extraction). There was no evidence that the recommended scaling was addressed. Interview was conducted with the residential Licensed Practical Nurse (LPN) on February 8, 2008 to ascertain if Resident #2 had received the recommended scaling. The LPN verified that calls were made as late as May 2007 to find out if the preauthorization for the service was granted, however, at the time of the survey, the facility failed to provide evidence that Resident #2 received the recommended dental service (scaling). (See also Federal Deficiency Report Citation W356)	I 401	Individual #2 dental appointment is scheduled In the future, the facility nurse will ensure that the dental treatment is completed as scheduled. In the event of the pre-authorization, the nurse will follow-up by calling the dentist's office on a regular basis, and document the attempts. Individual #2 dental appointment is scheduled In the future, the facility nurse will ensure that the dental treatment is completed as scheduled. In the event of the pre-authorization, the nurse will follow-up by calling the dentist's office on a regular basis, and document the attempts.	4-07-08 4-07-08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by:	I 422		

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I 422	Continued From page 13 Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for two of the two residents (Residents #1 and #2) included in the sample. The finding includes: 1. Review of Resident #1's Individual Program Plan (IPP) dated December 27, 2007 on February 8, 2008, revealed a program objective in the daily living domain that indicated that the Resident "will remove nail polish from her fingernails with gestural prompts from staff on 8/10 consecutive trails . . ." Review of the available program data for January 2008 through February 2008, revealed that the program could not be run due to the resident not having any nail polish on. 2. Review of Resident #1's IPP dated December 27, 2007 on February 8, 2008, revealed a program objective in the money management domain that indicated that the Resident "will make a purchase of at least two items that she she likes with verbal prompts from staff on three -4 trials per month . . . " Review of the program data revealed that on January 19, 2008 the program could not be implemented due to "no van." (See Federal Deficiency Report Citation W249)	I 422	Refer to W 249 (1) P. 20 Refer to W 249 (2) P. 20	2-08-08 2-12-08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal	I 500		

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I 500	Continued From page 14 laws. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the protections of each residents rights, for one of the two residents (Resident #2) included in the sample. The finding includes: The facility failed to provide evidence that informed consent was obtained from Resident #2 and/or her legal guardian for sedations given during medical appointments. Review of Resident #2's records on February 7, 2008, at approximately 2:47 PM revealed a written physician order (dated October 14, 2007) that documented the Resident was to receive Xanax 2 mg one hour before her gynecological appointment on October 17, 2007. Additional review of Resident #2's record on February 8, 2008 at 3:43 PM revealed orders dated January 20, 2008, and February 1, 2008, that documented the Resident was prescribed Xanax 2 mg one hour before her MRI on January 23, 2008, and February 6, 2008, respectively. It should be noted that interview with the Licensed Practical Nurse (LPN) on February 8, 2008 revealed the medications were administered to address behaviors during medical appointments and further verified that the sedations were administered. Interview with the Qualified Mental Retardation Professional (QMRP) on February 7, 2008 at 10:27 AM revealed that Resident #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The	I 500	Refer to W 278 P. 22	3-01-08

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I 500	Continued From page 15 QMRP's statement was verified on February 8, 2008 at 1:40 PM through review of Resident #2's psychological assessment dated September 10, 2007. According to the assessment, Resident #2 "does not evidence the capacity to make decisions on her behalf in treatment/habilitation, on going medical care, residential placement, and financial matters." Additionally, the QMRP revealed that Resident #2 did not have a legal guardian but did have involved family members. At the time of the survey, however, the facility failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative for the use of the aforementioned sedations. (See also Federal Deficiency Report Citation W124)	I 500	Refer to W 124 P.4	2-08-08
I 999	FINAL OBSERVATIONS The following environmental observations were made during the survey process on February 8, 2008. It is recommended that these areas be reviewed and a determination be made regarding appropriate action to prevent potential deficient practices: a. Stains on the living room furniture; and b. The filter on the range hood was heavy accumulation of grease.	I 999	The stain on the living room furniture was cleaned The grease on the filter on the range hood was cleaned In the future, the facility will ensure that the furniture, and household appliance are cleaned.	2-08-08 2-08-08

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R 000	INITIAL COMMENTS An annual relicensure survey was conducted from February 7, 2008 through February 8, 2008. A random sample of two residents was selected from a residential population of five residents (one male and four females) with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on February 7, 2008, revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for six staff. It	R 125	All of the staff criminal background will be on file In the future the administration will ensure that all personnel record are on fil, and availble upon request.	3-15-08.

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 3/3/08

STATE FORM 6899 GRJC11 If continuation sheet 1 of 2

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FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G072	A. BUILDING _____ B. WING _____	02/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1318 45TH PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 1 should be additionally noted that review of the personnel records for four staff failed to provide enough information to ascertain a seven year history of where the employee resided and/or worked.	R 125		